

To: Joint Select Committee on Health Care Reform Opportunities and Implementation

From: Colleen McCarthy Reid

Date: August 11, 2010

RE: August 10 Meeting Summary--Health Reform Implementation Steering Committee

The Health Care Reform Implementation Steering Committee (created by Executive Order) held a public meeting today in Room 209, Cross State Office Building. The following members of the Steering Committee attended: Trish Riley, Director of the Governor's Office of Health Policy and Finance; Ellen Schneider, Acting Commissioner of the Department of Administrative and Financial Services; Ann Head, Commissioner of the Department of Professional and Financial Regulation; Brenda Harvey, Commissioner of the Department of Health and Human Services; Mila Kofman, Superintendent of the Bureau of Insurance; and Karynlee Harrington, Executive Director of the Dirigo Health Agency. Beth Waldman and Amy Lischko, consultants from Bailit Health Purchasing LLC, also attended.

Updates on Activities

New website. The Governor's Office has developed a new website for information on Maine's health reform implementation process, www.maine.gov/healthreform.

Meeting with federal officials; notice for public comment--exchanges. Ms. Riley briefed the Steering Committee on a meeting she attended last week with U.S. Department of Health and Human Services officials and key officials from other states. Karynlee Harrington also attended. The meeting was convened to gather input from states as the federal government begins the planning and implementation process for exchanges. Another meeting is planned for state health reform planning teams in Vermont on Sept. 13 and 14. Ms. Riley indicated all of the steering committee members will attend. The Department of Health and Human Services also issued a notice for public comment on August 3, 2010 to solicit input on the development of exchanges. Comments are due October 4, 2010. A copy of the notice is posted on the Joint Select Committee's website.

Planning Grant for Exchanges. The federal government issued the announcement for planning grants on July 29, 2010. Grant applications are due September 1st. Ms. Riley stated that the grant proposal was under development and on track. Because of the timeframe, the steering committee will use email to review and comment on the draft proposal. Ms. Riley also indicated that she would solicit input on the planning grant from the chairs of the Legislature's Joint Select Committee. A copy of the grant announcement is posted on the Joint Select Committee's website.

Department of Health and Human Services Grants. Commissioner Harvey updated the steering committee on grant opportunities within the Department of Health and Human Services. She reported that the Office of Elder Services has applied for 4 grants to support long-term care programs and services. The Center for Disease Control also plans to submit applications for 3 grants due Sept. 2 related to tobacco prevention and control, HIV/AIDS disease surveillance and infectious disease surveillance. Commissioner Harvey also mentioned that the DHHS has applied for a \$3 million grant for the TANF program aimed at health care workforce training (although this is not a grant made under the ACA, it is health care-related.)

Consumer Assistance Grant. Grant applications are due Sept. 10 from states for consumer assistance and advocacy activities; the minimum award is \$120,000 per state. Because the focus of the grant funding is consumer assistance and advocacy, the Bureau of Insurance has determined that they are not the appropriate state entity. Superintendent Kofman explained that the bureau regulates insurance and, as such, must maintain its independence from advocating on behalf of consumers against the industry it is regulating. Trish Riley noted that she has had preliminary discussions with the Attorney General's Office about the grant. While discussions are ongoing, she indicated that the

Attorney General's Office may pursue the grant in partnership with Consumers for Affordable Health Care.

Rate Review Grant. The Bureau of Insurance is still waiting for a decision on its application for grant funding to assist in its review of health insurance rates. Announcements of the grant awards are expected this month.

Impact of Affordable Care Act (ACA) on Businesses

Beth Waldman gave a slide presentation on the impact of the Affordable Health Act (ACA) on Maine businesses. *See attachment; slides also posted on Joint Select Committee's website.* Ms. Waldman reviewed the requirements for the individual and employer mandates. Ms. Waldman also reviewed the small business tax credits and new reporting requirements for employers. Finally, Ms. Waldman reviewed the insurance market changes, including the ability for employer health plans to be "grandfathered" plans not subject to certain requirements.

Ms. Waldman outlined several key policy decisions that may impact small businesses and the insurance market, including outreach and education for small businesses, subsidies to incent small businesses to purchase health insurance and changes to insurance laws on community rating, mandated benefits and the size of the individual and small group health insurance markets. Next steps will include the development of a white paper describing the impact on businesses in more detail and the policy options for the Governor and Legislature.

On August 27th, Ms. Waldman will make a similar presentation to the Advisory Council on Health Systems Development.

Next meeting

Ms. Riley explained that the next steering committee meeting will be held on September 21st from 3pm to 5pm; the meeting date and time was changed to accommodate the Joint Select Committee's request to have a presentation earlier that day from Amy Lischko, consultant to the steering committee.

PUBLIC MEETING OF STEERING COMMITTEE ON HEALTH REFORM

AGENDA

AUGUST 10, 2010

9:00 AM – 12:00 NOON

ROOM 209, HHS COMMITTEE ROOM, CROSS OFFICE BUILDING, AUGUSTA

LIVE AUDIO OF THIS MEETING IS AVAILABLE BY ACCESSING

http://www.maine.gov/legis/audio/health_cmte.html

- 1) Report from State Leads Meeting with Federal Officials
- 2) New Grant Opportunities
 - Exchange Planning
 - Consumer Ombudsman
- 3) Impact of ACA on Business – Beth Waldman, Sr. Consultant, Bailit Health Purchasing, LLC
- 4) Other
- 5) Public Comment
- 6) Adjourn

Impact of the ACA on Maine's Businesses

Presented to the Health Reform
Implementation Steering Committee

August 10, 2010

Beth Waldman, JD, MPH

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PROFESSIONAL

Today's Agenda

- The long-term opportunity of health reform
- Discussion of Key Components of ACA from Employer Perspective:
 - Individual and Employer Mandates
 - Employer Tax Rules
 - Health Plan Offerings
 - Required Benefits and Insurance Reforms
 - Employer Wellness Opportunities & Incentives
 - Long Term Care
 - Opportunities for Cost Containment
- Collect policy issues that need to be decided by the Legislature
- Develop work plan that includes both identified issues and other activities to be completed

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DRAFT: FOR DISCUSSION
ONLY

Overarching Goals of Health Reform

- Three major goals in passing national health reform:
 - Near universal access
 - Improved quality
 - Improved affordability to employers and individuals
- Standardized Medicaid eligibility to 133% and subsidized insurance for individuals to 400% of FPL; coupled with mandates for insurance will increase access
- Increased focus on quality measurement nationally and development of national standards will improve quality

Increased affordability of coverage

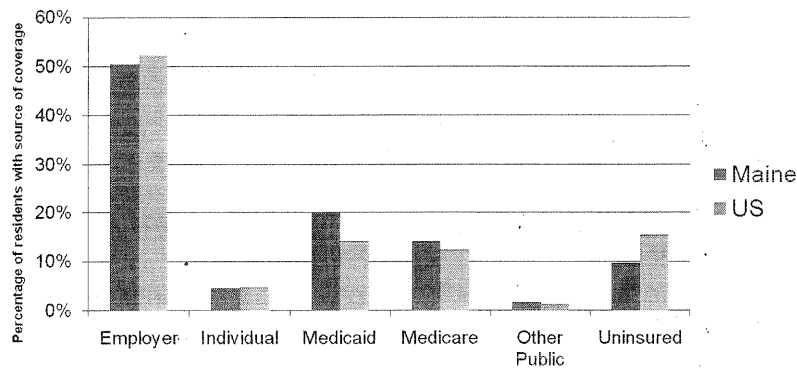
- Goal to be accomplished through:
 - Increased transparency of health care costs and premiums
 - National review of unreasonable premium rate increases
 - Continued review of rates at state level
 - Medical loss ratio requirements
 - Taxes on insurer premiums
 - Tackling administrative costs
 - Greater efficiencies in private market through standardization
 - Use of Exchange to full potential
 - Increased access to health care
 - Reduced uncompensated care and impact on premiums
 - Funding of demonstration programs to contain costs
 - ACOs
 - Patient centered medical home
 - Payment reform
 - Temporary increase of Medicaid primary care physician reimbursement rates
 - To reduce cost shift
 - To shift locus of care

Health Reform's Opportunities For Employers and Individuals

- Increased access to coverage likely to keep individuals healthier and require fewer missed working days
- Increased transparency will require insurers (and the providers in their network) to justify rate increases leading to potentially reduced rates of premium growth for both employers and individuals
 - MLR for large group (first time in ME)
- Increased standardization of insurance through use of Exchange will facilitate informed purchasing decisions
- Increased focus on quality and payment reform should also help to contain health care costs

Most coverage comes through employers

Source of insurance coverage, Maine and U.S.



Note: 2008 data for the US; ME data is aggregated 2007-2009

Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2008 and 2009 Current Population Survey (CPS: Annual Social and Economic Supplements).

Process for Implementing ACA

- Varying provisions become effective between date of passage (April 2010) through 2017; most provisions become effective by January 1, 2014.
- The ACA requires detailed regulations to implement
 - Federal government moving to develop regulations as quickly as possible
 - Utilizing National Association of Insurance Commissioners (NAIC)
 - Actively working with National Governor's Association (NGA) and National Association of State Medicaid Directors (NASMD)
 - Utilizing public comment periods to receive feedback from all stakeholders
 - For implementation dates of activities or changes that are further off, lack of regulations creates uncertainty
 - Lobbying continuing at congressional and executive level

Individual Mandate to Purchase Health Insurance

- Individuals required to have health insurance beginning in 2014
- Lack of insurance will result in a tax penalty
 - Penalty phased in: \$95 or 1% of household income (2014); \$325 or 2% of household income (2015)
 - Maximum penalty of \$695 per person; with family total of \$2,085; or 2.5% of household income (2016); after 2016 will annually increase through cost-of-living adjustments
 - Exemptions from penalty for low-income, financial hardship and other reasons

How Individuals Might Respond to the Mandate

- Subsidy for eligible individuals through the Exchange
 - Some employees may move from employer-sponsored insurance to the Exchange (employer still responsible if greater than 50 employees and/or where the employee is eligible for free choice voucher)
- Increased take up of employer-sponsored insurance
- Increased enrollment in public programs
 - Based on National standardization of eligibility
- Enrollment of individuals in plans offered through the Exchange

Premium Subsidies Available if Purchase Coverage Through Exchange

- Individual premium subsidies will be provided as refundable and advanceable premium credits toward purchase of coverage through the Exchange beginning in 2014
- Will be tied to second lowest cost silver plan in the Exchange and set on sliding scale so not more than a % of income:
 - Up to 133% FPL: 2% of income
 - 133-150% FPL: 3-4% of income
 - 150-200% FPL: 4-6.3% of income
 - 200-250% FPL: 6.3-8.05% of income
 - 250-300% FPL: 8.05-9.5% of income
 - 300-400% FPL: 9.5% of income
 - > 400%: no public subsidy available

What is a Silver Plan?

- Under the ACA, an insurance offering will be considered a Silver Plan if it is equal to 70% of the actuarial value
 - Means that out of pocket costs will total 30% (if no subsidy)
- Plans must offer the essential health benefits, and will compete by:
 - Premium cost
 - Deductibles & co-payment structure
 - Network
 - Quality (using criteria developed by HHS)

Cost Sharing Subsidies

- Available for low-income subsidized individuals
- For coverage purchased in the Exchange
- Reduces the cost-sharing amounts and annual cost-sharing limits; increases actuarial value of essential benefit plan to:
 - 100-150% FPL: 94%
 - 150-200% FPL: 87%
 - 200-250% FPL: 73%
- No cost-sharing subsidies above 250% FPL; actuarial value remains at 70%

Current FPL Chart (updated each April)

FPL	% Income for HI	Annual Income (Individual)	Maximum Annual Cost of HI
133%	3.00%	\$13,579	\$407
150%	4.00%	\$15,315	\$613
175%	5.15%	\$17,868	\$920
200%	6.30%	\$20,420	\$1,286
225%	7.18%	\$22,973	\$1,649
250%	8.05%	\$25,525	\$2,055
275%	8.78%	\$28,078	\$2,465
300%	9.50%	\$30,630	\$2,910
325%	9.50%	\$33,183	\$3,152
350%	9.50%	\$35,735	\$3,395
375%	9.50%	\$38,288	\$3,637
400%	9.50%	\$40,840	\$3,880

Employer Coverage Requirements (1 of 3)

- Employers with 50 or more full time equivalent employees are required to offer health insurance beginning in 2014 or pay an assessment
 - Full time employees:
 - Includes individuals that work 30 or more hours per week;
 - Includes full time equivalents
 - Excludes full-time seasonal employees who work fewer than 120 days during the year

Example of Large Employer Calculation

- Employer has 35 full-time employees (work 30+ hrs)
- Employer also has 20 part-time employees that work 24 hrs each per week
- Calculation:
 - $20 \text{ 'ee} \times 96 \text{ hr} = 1920/120 = 16 \text{ full-time equivalents}$
 - $35 + 16 = 51$
- Employer in this example considered large employer

Employer Coverage Requirements (2 of 3)

- Penalty Calculation.
 - If do not offer, will be required to pay penalty:
 - If have at least one full time employee receiving a premium tax credit;
 - \$2000 per FTE (excludes first 30 FTEs)
 - If offer and have FTE who receives a premium tax credit, will pay lesser of \$3000 for each FTE receiving a credit or \$2000 for each FTE (less first 30)
 - Part time workers are not included in penalty calculations
 - Seasonal worker may be included in penalty calculations

Example:

Large Employer Does Not Offer Coverage

- Assume 51 employees; 1 or more purchases through Exchange with subsidy
 - Annual Penalty: # of full-time employees (35) – 30 = 5 X \$2000 = \$10,000
- If no employee purchases through Exchange with subsidy, then no penalty assessed

Employer Coverage Requirements (3 of 3)

- Employers of all sizes that offer coverage required to participate in the free choice voucher program
 - Available to employees with income less than 400% FPL, if share of premium exceeds 8% but is less than 9.8% of total family income
 - Voucher equal to what employer would have paid under own plan (age adjusted)
 - Employee enrolls in Exchange plan
 - Employer not subject to penalties for these employees
- Employers with more than 200 employees must automatically enroll employees into plan; employees may opt out
- Employers not required to have same plan for all employees (but must comply with non-discrimination rules)

Example: Large Employer That Offers Coverage

- Assume 100 employees; 15 purchase in the exchange with subsidy (but no free choice voucher)
 - Annual Penalty: # of employees with subsidy (15) X \$3000 = \$45,000
- Assume 100 employees; 15 purchase in the exchange with subsidy (5 have free choice voucher)
 - Annual Penalty: # of employees with subsidy and no free choice voucher (10) X \$3000 = \$30,000
- Assume 100 employees; 50 purchase in exchange with subsidy (but no free choice voucher)
 - Annual Penalty: # of employees with subsidy (50) X \$3000 = \$150,000; Limit of 140,000 (70 X 2,000).
Annual Penalty = \$140,000

Tax Changes in the ACA

- Employer Tax Credits for small employers with low-income work force
- Increased taxes to some businesses and individuals
- Tax incentives

Small Business Tax Credits (1 of 3)

- Helps small businesses and small tax-exempt organizations afford cost of health insurance for employees
 - Available whether new coverage or maintaining coverage
 - IRS sent postcards in April to potentially eligible businesses
 - HHS estimates that over 22,000 businesses in Maine are potentially eligible for credit
- Available to small employers with no more than the equivalent of 25 full-time employees and average annual wages of less than \$50,000, that purchase health insurance for employees
 - Not available to sole proprietors/self-employed
 - Still a deductible budget expense
- Tax credits can be applied either to income taxes paid or taxes withheld for their employees
 - If cannot use tax credit in one filing year, will remain for a future filing year

Small Business Tax Credit (2 of 3)

- Phase One – Underway (2010-2013)
 - Tax credit of up to 35% of employer's premium contribution toward employee health insurance, if employer pays at least 50% of premium. Credit available for four years.
 - Full credit available to employers with 10 or fewer employees and average wages less than \$25,000 (credit to equal between 25-35% of employer's premium contribution).
 - Partial credit available as firm size and average wage increases (credit up to 25% of employer's premium contribution)

Small Business Tax Credit (3 of 3)

- Phase Two: 2014 and beyond
 - Small business must purchase coverage through the Exchange
 - Eligible for tax credit of up to 50% of employer's contribution if contribute at least 50% of premium cost
 - Credit available for two years only (rolling basis)
 - Credits received before 2014 do not count to two year limit
 - Full and partial credit similar to Phase One
 - Full credit if 10 or fewer and annual income of less than \$25,000 (credit equal to between 35-50%)
 - Partial credit (up to 35%)

Employer Reporting Requirements (1 of 2)

- Effective 1/12: All employers must include value of employees health insurance coverage on the W2
- Why:
 - Help determine individual mandate
 - Provide transparency in value of coverage
 - Start readying for "Cadillac tax"
- To date, no guidance has been released by IRS

Employer Reporting Requirements

(2 of 2)

- To allow the Treasury Secretary to determine whether an employer is meeting coverage requirements, annual reporting of type of health coverage offered required beginning in 2014
- Report due on 1/31 and will include:
 - Name/address/employer ID number
 - Certification of whether employer offers insurance to FTEs and dependents
 - Opportunity to enroll in minimum essential coverage
 - Length of any waiting period
 - Months coverage was available
 - Monthly premiums for lowest-cost option
 - Employer plan's share of covered health care expenses
 - Number of FTEs and names/identification

Employer Information Requirements

- Must provide information on employer plan to each employee (3/23/12):
 - A summary of benefits and coverage before enrollment or when existing enrollees re-enroll
 - Meet standards to be developed by Federal government, with input from stakeholders, on form and content, including standardized definitions of key terms.
 - No more than 4 pages in length; 12 pt font
 - Written in culturally & linguistically appropriate manner
 - The Secretary must develop the standards by 3/23/11 to be effective 3/23/12.
- Must provide employee with information on the exchange (3/1/13)
 - Must include services and contact information
 - Employee's potential eligibility for premium credits & cost-sharing subsidies if the employer plan's actuarial value is less than 60% (or unaffordable based on income)
 - Employee's potential loss of any employer contribution if purchase through the exchange and is not eligible for a free choice voucher

Tax Changes Related to Health Insurance (1 of 2): Impact to Individuals

- Tax penalty for failure to comply with individual mandate
- Limitations on FSAs, MSAs, HSAs that reduce ability of individuals to use pre-tax dollars to pay for medical expenses not covered by insurance
 - Over the counter drugs not prescribed by physician can't be reimbursed through a FSA, HSA, MSA (1/11)
 - Increases tax on distributions from HSA that are not used for medical expense (to 20% from 10 or 15%)(1/11)
 - Limit FSA contributions to \$2,500 (effective 1/13)
- Increase threshold for itemizing deductions related to medical expense (to 10% from 7.5%) (effective 1/13; waived from 2013-2016 for individuals 65 & older)
- Imposes a 3.8% tax on unearned income for higher-income tax payers (1/13)
 - Will apply to only 1.5% of Maine taxpayers (incomes above \$200,000 for individuals or \$250,000 for couples)

Tax Changes Related to Health Insurance (2 of 2): Impact to Employers

- Increase in Medicare Part A tax rate on wages by .9% for individuals with incomes over \$200,000 and couples with incomes over \$250,000 (effective 1/13)
- Eliminate tax deduction for employers who receive Medicare Part D retiree drug subsidy payments (1/13)
- Impose excise tax on insurers of employer-sponsored health plans with an aggregate cost that exceed \$10,200 for individual coverage and \$27,500 for family coverage (1/18; indexed to CPI-U in 2020)
 - Excise tax will be 40% of the value of the plan that exceeds the threshold amounts and is imposed on the issuer of the health insurance policy (insurer; or employer if self-insured)
 - Aggregate cost includes reimbursements under a HSA

Fiscal Responsibility for Health Reform (1 of 2)

- New annual fees on pharmaceutical manufacturing sector (nationally between \$2.8B and \$4.1B annually; less than 1% of annual revenue of over \$271B)(2012)
- New annual fees on the health insurance sector (nationally between \$8B and \$14.3B annually; less than 3% of annual revenue of over \$382B) (2014)
 - For non-profit insurers only 50% of net premiums used in calculating fee
 - Exemptions for non-profit that receive more than 80% of income from government programs
- Excise tax of 2.3% on any taxable medical device (2013)
 - Excludes eyeglasses, contact lenses, hearing aides and anything determined by Secretary to be individually purchased in retail setting
 - Tax is on the manufacturer

Fiscal Responsibility for Health Reform (2 of 2)

- Limits deductibility of executive and employee compensation to \$500,000 per applicable individual for health insurance providers (effective retro to 1/09)
- Impose 10% tax on tanning services (July 2010)
- Excludes unprocessed fuels from definition of cellulosic biofuel for purposes of applying producer credit (January 2010)
- Clarifies application of economic substance doctrine and increase penalties for underpayments (April 2010)

Tax Incentives for Businesses

- 12 year patent protection for biologics
- Therapeutic discovery tax credit for drug development by small to medium life sciences companies

New Health Plan Offerings

- What insurance may be purchased
 - Essential benefit plans
 - Impact on state mandates
 - Standard plans
 - Medical Loss Ratio (MLR) requirements
- How can insurance plans be offered
 - Purchase of national plans through the Exchange
 - Potential for new carriers to enter Maine (both in & out of exchange)
 - Compacts with other states
 - Co-op plans

Essential Benefits Plans

- ACA requires specific minimum coverage within plans
 - Ambulatory and emergency services
 - Hospitalization
 - Maternity and newborn care
 - Mental health
 - Prescription drugs
 - Rehabilitation and devices
 - Laboratory
 - Preventive and wellness
 - Oral and vision (for pediatrics)
- HHS to issue implementing regulations
- Will need to review Maine's state mandated benefits against essential benefit plan

Standard Plans

- ACA requires four standard benefit plans to be offered within the Exchange; all must include essential health benefits.
- Standard plans are based on actuarial value of the plan: Platinum (90%); Gold (80%); Silver (70%) & Bronze (60%)
- Carriers can also offer a catastrophic product in the Exchange for people under 30 years old and others exempt from mandate; this is only available to individuals

Medical Loss Ratio Requirements

- Minimum medical loss ratio (MLR)
 - for small group insurers will be 80%
 - 85% for large group coverage
- Maine already has a pure MLR requirement. It requires:
 - 68% for individuals
 - 75% for small groups; 78% without approval
 - No MLR in the large group
- Reporting of MLR beginning plan year 2010
 - NAIC is charged with recommending the definition
- Required rebates to consumers in amounts equal to value of payments below 80% MLR beginning 1/11
- Lobbying to include certain administrative costs in MLR
 - e.g., cost of case management, DM and wellness programs, member call center
 - Maine asking for waiver from the individual MLR requirement because of market impact

Potential for New Plans to Enter the Market (1 of 2)

- National plans
 - Exchange must offer two multi-state plans
 - One plan must be a non-profit
 - Only available to individuals and small group
- Multi-state compacts
 - NAIC charged with developing standards for voluntary interstate compacts that will permit sales across state lines
 - Will provide guidance as to which state rules will be waived due to compact
 - Insurance companies are still required to be licensed in each state
 - Regulations due by July 1, 2013
 - States may enter into compacts beginning in January 2016
 - Maine will need to make a policy decision on whether to join a compact and if so, with what other states
 - Will require Legislative approval to enter into compact

Potential for New Plans to Enter the Market (2 of 2)

■ Consumer Operated and Oriented Plans (CO-OP) Program

- CO-OP Program is designed to foster the development of nonprofit, member-run health insurers for the individual and small group market
- CO-OP Plans will require state licensure
- ACA created an Advisory Board to the CO-OP Program; members appointed in June 2010
 - Board will assist and advise HHS on the strategy to foster CO-OPs
 - Will also make recommendations to HHS on grants and loans for the development of CO-OP plans by July 1, 2013.

Benefit Changes

- Short term:
 - Early retiree reinsurance program, effective 6/23/10 (time-limited, based on available funding)
 - Dependent Coverage extension, effective 9/23/10
 - No lifetime limits on policy coverage (9/23/10)
 - No pre-existing conditions on children (9/23/10)
 - Non-discrimination rules based on salary (9/23/10)
 - No member contribution on preventive care services, effective 1/1/11
 - New limits/rules on flexible spending accounts (some begin 1/1/11)
- Beginning in 2014:
 - No pre-existing conditions for adults
 - No annual limits on policy coverage
 - Limits on deductibles offered in small group plans
 - Standards on out of pocket costs
 - Employee waiting period limited to 90 days
- Grandfathered Plans

Early Retiree Reinsurance Program

- Relief for employers through a temporary reinsurance program for employers covering retirees over age 55, but not eligible for Medicare
- Pays 80% of retiree/dependent claims between \$15,000 - \$90,000
 - Payments retroactive for plan year
- Funds used to lower costs for employees/employers
- Operations:
 - on-line applications,
 - detailed claims submissions,
 - possible audits
- Began in June with on-line qualifying application
- \$5 billion available; program ends when funds disbursed
 - The State of Maine has applied for funding for coverage of retired state employees
- Program applications and more information is available at <http://www.hhs.gov/ociio/errp>

Dependent Coverage Extension

- Beginning 9/23, adult children must be covered until they turn 26 years old at option of the subscriber.
 - Applies to all plans, including grandfathered plans
- Maine already provides for extended dependent coverage. Key differences:
 - Maine law only requires that insurers offer to group (as opposed to group offering to family)
 - Maine law only goes up to age 25
 - Maine law does not apply to married dependents (federal law applies to all dependents regardless of marital status)
- Expected to have a small impact on premiums
(Mercer estimates between .25% to 2%)

No member contribution for preventive services

- Beginning 1/11, no cost-sharing can be required for specified preventive services, including:
 - For children: over 24 services including immunizations, preventive care, and screenings
 - For adults: screenings (cancer, depression, obesity); tobacco counseling for pregnant women
- Administration issued regulations in July 2010
- Does not apply to grandfathered plans
- Change aimed at improving access and improving health by preventing disease and finding treatable diseases early

Additional Requirements on Health Plans

- Development of uniform explanation of coverage documents and standardized definitions (2012)
- Administrative simplification requirements (Rules to be adopted by 7/2011 and effective by 1/2013)
- Submit annual reports of quality improvement benefits and reimbursement structures (2012)
- Must provide coverage for routine costs associated with clinical trials

Grandfathered Plans (1 of 3)

- What is a grandfathered plan?
 - Existing group health plan or health insurance coverage in which person enrolled as of March 23, 2010
 - Current enrollees may re-enroll in a grandfathered plan
 - Exempt from many – but not all – reforms in the ACA
- Administration issued interim final regulations in June
 - Try to balance dual goals of allowing individuals to keep current plans and ensuring that individuals receive consumer protection provisions of the ACA
- How do plans remain grandfathered:
 - Employers must not significantly lower contribution to health care premiums (more than 5% below rate in March 2010)
 - Employers cannot raise cost-sharing above certain limits (medical inflation plus 15% points)
 - Employers cannot reduce current benefits
 - Employers cannot reduce annual limits

Grandfathered Plans (2 of 3)

- What changes can an employer make and stay grandfathered:
 - Increase number & types of benefits
 - Changes to comply with state/federal regulations
 - Voluntarily adopt provisions w/in ACA that not required to b/c of grandfathered status
 - Modest adjustments to benefits, cost-sharing & premiums

Grandfathered Plans (3 of 3)

- If a plan is “grandfathered” from ACA than it does not need to meet the following new requirements:
 - Pre-existing conditions
 - Essential benefit package requirements
 - Rules on deductible maximums and out-of-pocket maximums
 - Required coverage of preventive services with no cost-sharing
 - Internal and external appeal process rules
 - No prior authorization for ob-gyn visits
 - Emergency care must have same payment in and out of network, and
 - Nondiscrimination based upon salary
- Changes that apply to Grandfathered Plans:
 - Allowing children to stay/join parents policy until age 26
 - Prohibition on lifetime limits
 - Waiting period no longer than 90 days
 - Medical Loss Ratio requirements
 - Rescissions can only be made for fraud or intentional misrepresentation of material fact

Community Rating Changes

- The ACA requires minimum community rating standard for age of 3:1 and for tobacco use of 1.5:1
 - Premium band can be +/- 50%
- Maine has a tighter requirement today at 1.5:1 for both age and geography:
 - Premium band can be +/- 20%
 - This means that age and geography have less impact on what people pay for insurance
- State will need to make a policy decision as to whether to stay with its current rating or to move to federal minimum
 - A move to 3:1 would result in lower health insurance costs for younger adults and higher costs as persons age

Employer Wellness Opportunities

- Small businesses may receive government grants for up to 5 years to establish wellness programs, effective October 2010.
- Greater flexibility for employers to offer employee rewards (e.g., premium discounts, cost-sharing waivers, new benefits), effective 1/14
 - Valued up to 30% of cost of participating in wellness programs; up to 50% if deemed appropriate
 - For employees participating in a wellness program or meet health goals (e.g., stop smoking)
 - Employer must offer alternatives when person unable or inadvisable to participate

Community Living Assistance Services & Supports (CLASS)

- Voluntary program to plan early for future long-term care needs (purchasing community living assistance services), effective 1/11
- If an employer offers a payroll deduction, all working adults must be automatically enrolled by employer unless opt out
 - If employers do not offer a payroll deduction; if not, employees will pay in through alternative methods to be developed by Secretary
 - Employers are not required to contribute
- Funded through payroll deductions; will be deposited into a national trust fund
- After 5 years of contributions (earliest 2016), individuals with functional limitations may receive no less than \$50 per day to purchase non-medical supports/services to remain in the community (e.g. home aides, wheelchair ramps)

ACA's effect on Medicare Part D

- Closing the "doughnut hole"
 - 2010: \$250 rebate
 - 2011: 50% discount for brand name drugs; begin federal subsidies for generics
 - 2013-2020: phase in subsidies for brand names and generics to close cost-sharing gap.
- Other changes
 - Eliminates tax deduction for employers that receive Part D retiree drug subsidy payments (effective 2013)
 - Reduced Part D premium subsidies for people with high-incomes
 - Support for low-income assistance programs

Cost Containment within ACA

- ACA provides many opportunities through:
 - Payment/system reform initiatives
 - Increased quality measurement
 - Reduced administrative burdens through standardization
- Healthcare Providers making anticipatory changes
 - Momentum in Maine and across the country to implement ACOs and payment reform strategies
 - Many physicians becoming hospital employees
 - Initiatives underway on developing ACOs
 - ACHSD Payment Reform workgroup

Required Legislative/Regulatory Changes

- Insurance reforms in ACA require Maine to make a number of legislative and regulatory changes to be in compliance with federal law.
- Changes that go into effect in 2010 can be made prior to legislative action through authority of Bureau of Insurance

Policy Decisions for Maine

- Decisions that would impact small businesses:
 - What information can the state provide to small businesses to educate re: availability of tax credits?
 - What is the role of the Navigator? What standards will be placed on the Navigator? How does the role of the Navigator impact the role of brokers?
 - Does Maine want to continue to provide subsidies to small employers to purchase coverage?
- Decisions that would impact insurance market:
 - Should the individual and small group markets be merged?
 - Should the state increase its small group market from 50 to 100, prior to required increase in 2016?
 - What changes, if any, should state make to its community rating standards?
 - What changes, if any, should state make to its mandated benefits?
 - Does Maine want to have an active insurance market outside of the Exchange?

Next Steps

- Develop white paper that describes impact of ACA on businesses
- Develop policy options and/or decision structure from upcoming policy decisions
- Present to the Advisory Committee on Health Care and System Development (ACHSD)

claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Do not submit information that you consider to be CBI or otherwise protected through <http://www.regulations.gov>, or e-mail. The Federal <http://www.regulations.gov> Web site is an "anonymous access" system, which means EPA will not know your identity or contact information unless you provide it in the body of your comment. If you send an e-mail comment directly to EPA without going through <http://www.regulations.gov>, your e-mail address will be automatically captured and included as part of the comment that is placed in the public docket and made available on the Internet. If you submit an electronic comment, EPA recommends that you include your name and other contact information in the body of your comment and with any disk or CD-ROM you submit. If EPA cannot read your comment due to technical difficulties, and cannot contact you for clarification, EPA may not be able to consider your comment. Electronic files should avoid the use of special characters or any form of encryption, and be free of any defects or viruses. (For additional information about EPA's public docket, visit the EPA Docket Center homepage at <http://www.epa.gov/dockets/>).

Docket: All documents in the docket are listed in the <http://www.regulations.gov> index. Although listed in the index, some information is not publicly available, e.g., CBI or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, will be publicly available only in hard copy. Publicly available docket materials are available either electronically in <http://www.regulations.gov> or in hard copy. You can view and copy the records related to this codification effort in the EPA Region 2 Library by appointment only. To make an appointment please call (212) 637-3185.

FOR FURTHER INFORMATION CONTACT: Michael Infurna, Division of Environmental Planning and Protection, EPA Region 2, 290 Broadway, 22nd floor, New York, NY 10007; telephone number (212) 637-4177; fax number: (212) 637-4377; e-mail address: infurna.michael@epa.gov.

SUPPLEMENTARY INFORMATION: In the "Rules and Regulations" section of this **Federal Register**, the EPA is codifying and incorporating by reference the State's hazardous waste program as a direct final rule. EPA did not make a proposal prior to the direct final rule

because we believe these actions are not controversial and do not expect comments that oppose them. We have explained the reasons for this codification and incorporation by reference in the preamble to the direct final rule. Unless we get written comments which oppose this incorporation by reference during the comment period, the direct final rule will become effective on the date indicated, and we will not take further action on this proposal. If we get comments that oppose these actions, we will withdraw the direct final rule and it will not take effect. We will then respond to public comments in a later final rule based on this proposal. You may not have another opportunity for comment. If you want to comment on this action, you must do so at this time.

For additional information, please see the direct final rule published in the "Rules and Regulations" section of this **Federal Register**.

Dated: April 27, 2010.

Judith A. Enck,
Regional Administrator, Region 2.
[FR Doc. 2010-18928 Filed 8-2-10; 8:45 am]
BILLING CODE 6560-50-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Part 170

Planning and Establishment of State-Level Exchanges; Request for Comments Regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act

AGENCY: Office of Consumer Information and Insurance Oversight, Department of Health and Human Services.

ACTION: Request for comments.

SUMMARY: This document is a request for comments regarding the Exchange-related provisions of the Patient Protection and Affordable Care Act (the Affordable Care Act), enacted on March 23, 2010. The Department of Health and Human Services (HHS) invites public comments in advance of future rulemaking and grant solicitations.

DATES: Submit written or electronic comments by October 4, 2010.

ADDRESSES: In commenting, please refer to file code OCHIO-9989-NC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

- **Electronically.** You may submit electronic comments on this regulation to <http://www.regulations.gov>. Follow the instructions under the "More Search Options" tab.

- **By regular mail.** You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: OCHIO-9989-NC, P.O. Box 8010, Baltimore, MD 21244-8010.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

- **By express or overnight mail.** You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: OCHIO-9989-NC, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.

- **By hand or courier.** If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

- a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445-G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

- b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244-1850.

If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786-9994 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Donna Laverdiere, Office of Consumer Information and Insurance Oversight, Department of Health and Human Services, at (301) 492-4100.

Customer Service Information: Individuals interested in obtaining information about the Patient Protection and Affordable Care Act may visit the Department of Health and Human Services' Web site (<http://www.HealthCare.gov>).

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments. All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all electronic comments received before the close of the comment period on the following public Web site as soon as possible after they have been received: <http://www.regulations.gov>. Follow the search instructions on that Web site to view public comments.

Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at Room 445-G, Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, call 1-800-743-3951.

I. Background

A. General

Title I of the Patient Protection and Affordable Care Act (Affordable Care Act, or the Act), Public Law 111-148, enacted on March 23, 2010, expands access to health insurance through the establishment of American Health Benefits Exchanges ("Exchanges"). Sections 1311(b) and 1321 (b) of the Affordable Care Act provide that each State may elect to establish an Exchange that would (consistent with definitions relating to the individual and group markets and employer size established in Section 1304 of the Act): (1) Facilitate the purchase of qualified health plans (QHPs); (2) provide for the establishment of a Small Business Health Options Program ("SHOP Exchange") designed to assist qualified employers in facilitating the enrollment of their employees in QHPs offered in the SHOP Exchange; and (3) meet other requirements specified in the Act. Additionally, section 1321(c)(1) requires the Secretary to establish and operate an Exchange within States that do not elect to establish an Exchange, or if the Secretary determines, on or before January 1, 2013, that the State will not have an Exchange operable by January

1, 2014 or has not taken the actions necessary to meet required Exchange standards as defined by regulation or to implement other requirements in Subtitles A and C of the Affordable Care Act (relating to insurance market reforms). For purposes of the remainder of this notice, the term "Exchange" will refer to State-operated Exchanges and the Exchange operated by the Federal government on behalf of States that do not elect to establish an Exchange.

B. Requirements for Establishing and Operating Exchanges

Section 1311(d) of the Affordable Care Act specifies certain requirements for Exchanges, and section 1311(e) specifies the requirements for a plan to be certified by the Exchange as a QHP. Additionally, Section 1321 of the Affordable Care Act discusses State flexibility in the operation and enforcement of Exchanges and related requirements. The Secretary will issue regulations setting standards for meeting the requirements under Title I of the Act with respect to the establishment and operations of the Exchanges. Each State electing to establish and operate an Exchange must have in effect Federal standards or a State law or regulation that implements the Federal standards within the State. Also, section 1311(k) specifies that Exchanges may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary under Subtitle D of the Affordable Care Act.

Section 1321(c) of the Act provides the authority for the Secretary to establish and operate an Exchange on behalf of a State that does not elect to establish an Exchange or that the Secretary determines will not have an Exchange operable by January 1, 2014; or has not taken the necessary actions to implement the requirements in 1321(a) or other market reforms specified in Subtitles A and C of Title I of the Affordable Care Act.

1. General Requirements for Exchanges

Section 1311(d)(1) requires that an Exchange must be a governmental agency or nonprofit entity established by a State. Section 1311(d)(2) requires Exchanges to make QHPs available to eligible individuals and employers. Section 1311(d)(6) requires Exchanges to consult with various stakeholders relevant to carrying out their responsibilities.

Section 1311(d)(4) identifies the minimum functions that an Exchange must perform. These functions include, but are not limited to: Implementing procedures for certification, recertification, and decertification of

QHPs; providing for the operation of a toll-free telephone hotline to respond to requests for assistance; maintaining an Internet website containing standardized comparative information on QHPs; assigning ratings to each QHP offered through the Exchange on the basis of relative quality and price, in accordance with criteria as defined by the Secretary; utilizing a standardized format for presenting health benefits options in the Exchange; consistent with requirements in Section 1413 of the Act, informing individuals of eligibility requirements for the Medicaid and CHIP programs or any applicable State or local public program, and enrolling individuals in those programs if the Exchange determines they are eligible through screening of the application by the Exchange; establishing and making available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit and cost-sharing reduction; granting certifications to individuals relating to hardship or other exemptions; and establishing a Navigator program consistent with the requirements in Section 1311(i).

2. Requirements Relating to Plan Ratings and Internet Portals

Section 1311(c)(3) requires the Secretary to develop a rating system that would rate QHPs offered through an Exchange on the basis of the relative quality and price. Additionally, Section 1311(c)(4) requires the Secretary to develop an enrollee satisfaction system that would evaluate the level of satisfaction with QHPs that had more than 500 enrollees during the previous year that are offered through an Exchange. The Act requires Exchanges to include quality and enrollee satisfaction ratings in the information provided to individuals and employers through their Internet portals.

Section 1311(c)(5) directs the Secretary to make a model template available to Exchanges for an Internet portal that may be used to direct eligible individuals and employers to QHPs; assist individuals and employers in determining eligibility for participation in Exchanges, premium tax credits, or cost-sharing reductions; and present standardized information (including plan ratings) to assist consumers in making health insurance choices. The Affordable Care Act also directs the Secretary to continue operating, maintaining and updating the Federal Internet portal developed under Section 1103(a) and to assist States in developing and maintaining their own portals.

3. Requirements Relating to Navigator Programs

Section 1311(i) provides that an Exchange shall establish a Navigator program under which it awards grants to eligible entities that meet the law's criteria, including demonstrating to the Exchange that they have existing relationships or could establish relationships with employers and employees, consumers, or self-employed individuals likely to be eligible to enroll in a qualified health plan. The duties of entities that serve as Navigators under such a grant include: Conducting public education activities to raise awareness of the availability of QHPs; distributing fair and impartial information concerning enrollment in QHPs and the availability of premium tax credits and cost-sharing reductions; facilitating enrollment in QHPs; providing referrals to any applicable office of health insurance consumer assistance, health insurance ombudsman, or other State agency to address enrollee complaints and questions about their health plans and coverage determination; and providing information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange. The Affordable Care Act directs the Secretary, in collaboration with States, to develop standards to ensure that information made available by Navigators is fair, accurate and impartial.

4. Other Requirements Relating to Exchanges

Section 1311(c)(6) requires Exchanges to provide for an initial open enrollment period (as determined by the Secretary no later than July 1, 2012), annual open enrollment periods (as determined by the Secretary), and special enrollment periods.

Section 1311(d)(5)(A) specifies that States must ensure that their Exchanges are self-sustaining on or after January 1, 2015, including allowing Exchanges to charge assessments or user fees to participating health insurance issuers, or otherwise generate funding to support their operations. Section 1311(d)(5)(B) prohibits wasteful use of funds by Exchanges. Additionally, Section 1313 requires Exchanges to keep an accurate accounting of all activities, receipts, and expenditures, and annually submit to the Secretary a report concerning such accounting. Section 1313(a) also specifies that the Secretary has certain enforcement authority if an Exchange or a State has engaged in serious misconduct related to compliance with Title I of the Act.

5. Establishment of Exchanges in the Territories

Section 1323 of the Affordable Care Act provides an opportunity for U.S. Territories to elect to establish Exchanges and appropriates a fixed amount of funds to reduce the cost of coverage provided through an Exchange in the Territories. The Act stipulates that Territories' elections related to establishing Exchanges must be consistent with Section 1321, relating to standards for establishing and operating Exchanges, and received not later than October 1, 2013.

II. Solicitation of Comments

Section 1321(a)(2) of the Affordable Care Act requires the Secretary to consult with stakeholders to ensure balanced representation among interested parties. HHS is inviting public comment to aid in the development of standards for establishment and operation of the Exchanges, to address other Exchange-related provisions in Title I of the Affordable Care Act, and to inform for the awarding of grants to the States to assist them in planning and developing Exchanges. The Department is interested in comments from all interested parties. To assist interested parties in responding, this request for comments describes specific areas in which the Department is particularly interested.

Commenters should use the questions below to provide the Department with relevant information for the development of regulations regarding the Exchange-related provisions in Title I of the Affordable Care Act. However, it is not necessary for commenters to address every question below and commenters may also address additional issues under the Exchange-related provisions in Title I of the Affordable Care Act. Individuals, groups, and organizations interested in providing comments may do so at their discretion by following the above mentioned instructions.

Specific areas in which HHS is particularly interested include the following:

A. State Exchange Planning and Establishment Grants

Section 1311(a) directs the Secretary to make planning and establishment grant awards to States for activities related to establishing an Exchange. For each fiscal year, the Secretary must determine the total amount that will be made available to each State. Grants awarded under this Section may be renewed if a State is making sufficient

progress toward establishing an Exchange, implementing other insurance market reforms, and meeting other benchmarks. The Secretary must make the initial grant awards under this Section no later than one year after enactment, and no grants shall be awarded after January 1, 2015.

1. What factors are States likely to consider in determining whether they will elect to offer an Exchange by January 1, 2014? To what extent are States currently planning to develop their own Exchanges by 2014 (e.g., become electing States) versus choosing to opt-in to an Exchange operated by the Federal government for their State? When will this decision be made? Can planning grants assist in identifying and assessing relevant factors and making this decision?

2. To what extent have States already begun to plan for establishment of Exchanges? What kinds of activities are currently underway (e.g., legislative, regulatory, etc.)? What internal and/or external entities are involved, or will likely be involved in this planning process?

a. What kinds of governance structures, rules or processes have States established or are they likely to establish related to operating Exchanges (e.g., legal structure (such as placement in State agency or nonprofit organization), governance structure, requirements relating to governing board composition, etc.)?

b. To what extent have States begun developing business plans or budgets relating to Exchange implementation?

3. What are some of the major factors that States are likely to consider in determining how to structure their Exchanges (e.g., separate or combined individual Exchanges and SHOP Exchanges; regional or interstate Exchanges; subsidiary Exchanges, State agency versus nonprofit entity)? What are the pros and cons of these various options?

4. What kinds of factors are likely to affect States' resource needs related to establishing Exchanges?

a. What is the estimated range of costs that States are likely to incur during the upcoming year (e.g., calendar 2010 through calendar 2011) for each of the major categories of Exchange activities? Which of these expenses are fixed costs, and which costs are variable?

b. To what extent do States have existing resources that could be leveraged as a starting point for Exchange operations (e.g., existing information technology (IT) systems, toll-free hotlines, Web sites, business processes, etc.)?

c. For what kinds of activities are States likely to seek funding using the Exchange establishment and planning grants?

5. What kinds of questions are States likely to receive during the initial planning and start-up phase of establishing Exchanges? How can HHS provide technical assistance, and in what forms, in helping States to answer these questions?

B. Implementation Timeframes and Considerations

Section 1321(b) requires each State that elects to establish an Exchange meeting the Secretary's requirements to have an Exchange operational by January 1, 2014. Section 1321(c) directs the Secretary to establish and operate an Exchange within each State that: (1) Does not elect to establish an Exchange; or (2) the Secretary determines will not have an Exchange operational by January 1, 2014, or has not taken the actions the Secretary determines necessary to implement the requirements in Section 1321(a) or the other insurance market reform requirements in Subtitles A and C of Title I of the Act.

Additionally, the Affordable Care Act includes several statutory deadlines for the Secretary related to establishment of Exchanges, including:

- Issuing regulations and/or guidance relating to requirements for Exchanges, requirements for QHPs, and risk adjustment as soon as practicable;
- Awarding State planning grants no later than one year after enactment (March 23, 2011);
- Determining the dates of the initial open enrollment period by July 1, 2012;
- No later than January 1, 2013, determining States' readiness to have Exchanges operational and implement required insurance market reforms by January 1, 2014;
- No later than July 1, 2013, issuing regulations for health choice compacts and the CO-OP program, and awarding CO-OP program grants; and
- Having in place additional insurance market reforms and providing cost-sharing reductions beginning on January 1, 2014.

In order to carry out the Federal implementation activities to ensure Exchanges are fully operational on January 1, 2014, the Department is seeking comments from stakeholders relating to implementation timeframes.

1. What are the key implementation tasks that need to be accomplished to meet Exchange formation deadlines and what is the timing for such tasks? What kinds of business functions will need to be operational before January 1, 2014,

and how soon will they need to be operational?

2. What kinds of guidance or information would be helpful to States, plans, employers, consumers, and other groups or sectors as they begin the planning process?

3. What potential criteria could be considered in determining whether an electing State is making sufficient progress in establishing an Exchange and implementing the insurance market reforms in Subtitles A and C of Title I of the Affordable Care Act? What are important milestones for States to show they are making steady and sufficient progress to implement reforms by the statutory deadlines?

4. What other terms or provisions require additional clarification to facilitate implementation and compliance? What specific clarifications would be helpful?

C. State Exchange Operations

Section 1311(b) requires an Exchange to be established in each State not later than January 1, 2014 that: Facilitates the purchase of QHPs; provides for the establishment of a SHOP Exchange that assists small employers in facilitating the enrollment of their employees in QHPs offered in the small group market in the State; and meets additional requirements for Exchanges outlined in Section 1311(d). The Act requires the Secretary to publish regulations relating to the requirements for operating State Exchanges as soon as practicable, and provides various types of flexibility for States.

A number of additional programs established by the Act are closely related to the establishment of health insurance Exchanges, such as the Navigator program in Section 1311(i) and other consumer assistance programs. In addition, the insurance reforms, consumer protection provisions, and premium rating requirements will apply to plans both inside and outside the Exchanges.

1. What are some of the major considerations for States in planning for and establishing Exchanges?

2. For which aspects of Exchange operations or Exchange standards would uniformity be preferable? For which aspects of Exchange operations or Exchange standards is State flexibility likely to be particularly important?

3. What kinds of systems are States likely to need to enable important Exchange operational functions (e.g., eligibility determination, plan qualification, data reporting, payment flows, etc.), to ensure adequate accounting and tracking of spending, provide transparency to Exchange

functions, and facilitate financial audits? What are the relative costs and considerations associated with building Exchange operational, financial, and/or IT systems off of existing systems, versus building new stand-alone Exchange IT systems?

4. What are the tradeoffs for States to utilize a Federal IT solution for operating their Exchanges, as compared to building their own unique systems to conform to the current State environment? For what kinds of functions would it make more sense for States to build their own systems, or modify existing systems?

5. What are the considerations for States as they develop web portals for the Exchanges?

6. What factors should Exchanges consider in reviewing justifications for premium increases from insurers seeking certification as QHPs? How will States leverage/coordinate the work funded by the rate review grants to inform the decisions about which plans will be certified by QHPs?

7. To what extent are Territories likely to elect to establish their own Exchanges? What specific issues apply to establishing Exchanges in the Territories?

8. What specific planning steps should the Exchanges undertake to ensure that they are accessible and available to individuals from diverse cultural origins and those with low literacy, disabilities, and limited English proficiency?

9. What factors should the Secretary consider in determining what constitutes as wasteful spending (as outlined in Section 1311 (d)(5)(B))?

D. Qualified Health Plans (QHPs)

Section 1311(d)(2)(A) requires Exchanges to make QHPs available to qualified individuals and employers, and Section 1311(d)(4)(A) requires Exchanges to implement procedures for the certification, recertification, and decertification of health plans as QHPs, consistent with criteria developed by the Secretary under section 1311(c). This certification criteria include, at a minimum: Meeting marketing requirements; ensuring a sufficient choice of providers and providing information on the availability of providers; including essential community providers within health insurance plan networks; receiving appropriate accreditation; implementing a quality improvement strategy; utilizing a uniform enrollment form and a standard format to present health benefit plan options; and providing quality information to enrollees and prospective enrollees.

1. What are some of the major considerations involved in certifying QHPs under the Exchanges, and how do those considerations differ in the context of individual and SHOP State Exchanges, subsidiary Exchanges, regional or interstate Exchanges, or an Exchange operated by the Federal government on behalf of States that do not elect to establish an Exchange?

2. What factors should be considered in developing the Section 1311(c) certification criteria? To what extent do States currently have similar requirements or standards for plans in the individual and group markets?

a. What issues need to be considered in establishing appropriate standards for ensuring a sufficient choice of providers and providing information on the availability of providers?

b. What issues need to be considered in establishing appropriate minimum standards for marketing of QHPs and enforcement of those standards? What are appropriate Federal and State roles in marketing oversight?

3. What factors are needed to facilitate participation of a sufficient mix of QHPs in the Exchanges to meet the needs of consumers?

a. What timeframes and key milestones will be most important in assessing plans' participation in Exchanges?

b. What kinds of factors are likely to encourage or discourage competition among plans in the Exchanges based on price, quality, value, and other factors?

4. What health plan standards and bidding processes would help to facilitate getting the best value for consumers and taxpayers?

5. What factors are important in establishing minimum requirements for the actuarial value/level of coverage?

6. What factors, bidding requirements, and review/selection practices are likely to facilitate the participation of multiple plans in Exchanges? To what extent should the Exchanges accept all plans that meet minimum standards or select and negotiate with plans?

7. What are some important considerations related to establishing the program to offer loans or grants to foster the promotion of qualified nonprofit health plans under CO-OP plans? How prevalent are these organizations today? What is the likely demand for these loans and grants? What kinds of guidance are they likely to need from HHS and what legislative or regulatory changes are they likely to need from States?

8. Are there any special factors that are important for consideration in establishing standards for the

participation of multi-State plans in Exchanges?

9. To what extent are States considering setting up State Basic Health Plans under Section 1331 of the Act?

E. Quality

The Affordable Care Act requires the Secretary to develop a health plan rating system on the basis of quality and prices that would be used by the Exchanges and to establish quality improvement criteria that health plans must meet in order to be qualified plans for Exchanges.

1. What factors are most important for consideration in establishing standards for a plan rating system?

a. How best can Exchanges help consumers understand the quality and cost implications of their plan choices?

b. Are the measures and standards that are being used to establish ratings for health plans in the Medicare Advantage program appropriate for rating QHPs in the Exchanges? Are there other State Medicaid or commercial models that could be considered?

c. How much flexibility is desirable with respect to establishing State-specific thresholds or quality requirements above the minimum Federal thresholds or quality requirements?

2. What are some minimum standards or other factors that could be considered with respect to establishing quality measurement and improvement thresholds or quality requirements that should be met by QHPs? What other strategies, including payment structures, could be used by plans to improve the practices of plan providers?

F. An Exchange for Non-Electing States

Section 1321(c) requires that in the case of States that do not elect to establish Exchanges, or that the Secretary determines will not have Exchanges operational by January 1, 2014 or have not taken the necessary actions to implement the requirements in Section 1321(a) or other insurance market reforms specified in Subtitles A and C of Title I of the Act, the Secretary shall establish (directly or through agreement with a not-for-profit entity) and operate an Exchange within the State.

1. How can the Federal government best work to implement an Exchange in States that do not elect to establish or are unable to establish their own Exchanges?

2. Are there considerations for an Exchange operated by the Federal government on behalf of States that do not elect to establish an Exchange that

would be different from the State-run Exchanges?

G. Enrollment and Eligibility

Section 1411 of the Affordable Care Act requires the Secretary to establish a program for determining whether an individual meets certain eligibility requirements for Exchange participation, premium tax credits and cost-sharing reductions, and individual responsibility exemptions. Additionally, Sections 1412, 1413 and 2201 contain additional requirements to assist Exchanges by making advance determinations regarding income eligibility and cost-sharing reductions; providing for residents of each State to apply for enrollment in, receive a determination of eligibility for participation in, and continue participation in applicable State health subsidy programs; and simplifying and coordinating enrollment in the Exchanges, Medicaid and the Children's Health Insurance Program (CHIP).

1. What are the advantages and issues associated with various options for setting the duration of the open enrollment period for Exchanges for the first year and subsequent years? What factors are important for developing criteria for special enrollment periods?

2. What are some of the key considerations associated with conducting online enrollment?

3. How can eligibility and enrollment be effectively coordinated between Medicaid, CHIP, and Exchanges? How could eligibility systems be designed or adapted to accomplish this? What steps can be taken to ease consumer navigation between the programs and ease administrative burden? What are the key considerations related to States using Exchange or Medicaid/CHIP application information to determine eligibility for all three programs?

4. What kinds of data linkages do State Medicaid and CHIP agencies currently have with other Federal and State agencies and data sources? How can the implementation of Exchanges help to streamline these processes for States, and how can these linkages be leveraged to support Exchange operations?

5. How do States or other stakeholders envision facilitating the requirements of Section 1411 related to verification with Federal agencies of eligibility for enrollment through an Exchange?

6. What are the verification and data sharing functions that States are capable of performing to facilitate the determination of Exchange eligibility and enrollment?

7. What considerations should be taken into account in establishing

procedures for payment of the cost-sharing reductions to health plans?

H. Outreach

Section 1311(i) provides that Exchanges shall establish grant programs for Navigators, to conduct public education activities, distribute enrollment information, facilitate enrollment, and provide referrals for grievances, complaints, or questions.

1. What kinds of consumer enrollment, outreach, and educational activities are States and other entities likely to conduct relating to Exchanges, insurance market reforms, premium tax credits and cost-sharing reductions, available plan choices, etc., and what Federal resources or technical assistance are likely to be beneficial?

2. What resources are needed for Navigator programs? To what extent do States currently have programs in place that can be adapted to serve as patient Navigators?

3. What kinds of outreach strategies are likely to be most successful in enrolling individuals who are eligible for tax credits and cost-sharing reductions to purchase coverage through an Exchange, and retaining these individuals? How can these outreach efforts be coordinated with efforts for other public programs?

I. Rating Areas

Section 2701(a)(2) of the Public Health Service Act, as added by Section 1201 of the Affordable Care Act requires each State to establish one or more rating areas within the State for purposes of applying the requirements of Title I of the Affordable Care Act (including the Exchange provisions), subject to review by the Secretary.

1. To what extent do States currently utilize established premium rating areas? What are the typical geographical boundaries of these premium rating areas (e.g., Statewide, regional, county, etc.)? What are the pros and cons associated with interstate, statewide, and sub-State premium rating areas? What insurance markets are typically required to utilize these premium rating areas?

2. To the extent that States utilize premium rating areas, how are they established? What kinds of criteria do States and other entities typically consider when determining the adequacy of premium rating areas? What other criteria could be considered?

J. Consumer Experience

1. What kinds of design features can help consumers obtain coverage through the Exchange? What information are consumers likely to find useful from

Exchanges in making plan selections? Which kinds of enrollment venues are likely to be most helpful in facilitating individual enrollment in Exchanges and QHPs?

2. What kinds of information are likely to be most useful to consumers as they determine whether to enroll in an Exchange and which plans to select (within or outside of an Exchange)? What are some best practices in conveying information to consumers relating to health insurance, plan comparisons, and eligibility for premium tax credits, or eligibility for other public health insurance programs (e.g., Medicaid)? What types of efforts could be taken to reach individuals from diverse cultural origins and those with low literacy, disabilities, and limited English proficiency?

3. What are best practices in implementing consumer protections standards?

4. Given that consumer complaints can be an important source of information in identifying compliance issues, what are the pros and cons of various options for collecting and reporting Exchange-related complaints (e.g., collecting complaints at the Federal level, versus at the State or Exchange level)?

K. Employer Participation

Section 1311(b)(1)(B) provides for the establishment of Small Business Health Options Programs, referred to as SHOP Exchanges, which are designed to assist qualified employers in the State who are small employers in facilitating the enrollment of their employees in QHPs offered in the small group market in the State. Section 1304(b) provides that for plan years beginning before January 1, 2016, States have the option to define "small employers" as those with (1) 100 or fewer employees, or (2) 50 or fewer employees. Section 1312(f)(2)(B) specifies that beginning in 2017, States may elect to include issuers of health insurance coverage in the large group market to offer QHPs through the Exchange, and for large employers to purchase coverage through the Exchange.

In addition, employers that do not offer affordable coverage to their employees will also interact with the Exchanges including where their employees purchase coverage through the Exchange.

1. What Exchange design features are likely to be most important for employer participation, including the participation of large employers in the future? What are some relevant best practices?

2. What factors are important for consideration in determining the employer size limit (e.g., 50 versus 100) for participation in a given State's Exchange?

3. What considerations are important in facilitating coordination between employers and Exchanges? What key issues will require collaboration?

4. What other issues are there of interest to employers with respect to their participation in Exchanges?

L. Risk Adjustment, Reinsurance, and Risk Corridors

Sections 1341, 1342, and 1343 of the Act provide for the establishment of transitional reinsurance programs, risk corridors, and risk adjustment systems for the individual and small group markets within States.

1. To what extent do States and other entities currently risk-adjust payments for health insurance coverage in order to counter adverse selection? In what markets (e.g., Medicaid, CHIP, government employee plans, etc.) are these risk adjustment activities currently performed? To the extent that risk adjustment is or has been used, what methods have been utilized, and what are the pros and cons of such methods?

2. To what extent do States currently collect demographic and other information, such as health status, claims history, or medical conditions under treatment on enrollees in the individual and small group markets that could be used for risk adjustment? What kinds of resources and authorities would States need in order to collect information for risk adjustment of plans offered inside and outside of the Exchanges?

3. What issues are States likely to consider in carrying out risk adjustment for health plans inside and outside of the Exchanges? What kinds of technical assistance might be useful to States and QHPs?

4. What are some of the major administrative options for carrying out risk adjustment? What kinds of entities could potentially conduct risk adjustment or collect and distribute funds for risk adjustment? What are some of the options relating to the timing of payments, and what are the pros and cons of these options?

5. To what extent do States currently offer reinsurance in the health insurance arena (e.g., Medicaid, State employee plans, etc.) or in other arenas? How is that reinsurance typically structured in terms of contributions, coverage levels, and eligibility? How much is typically taken in and paid out? Is the reinsurance fund capped in any way?

6. What kinds of non-profit entities currently exist in the marketplace that could potentially fulfill the role of an "applicable reinsurance entity" as defined in the Act?

7. What methods are typically used to determine which individuals are deemed high-risk or high cost for the purposes of reinsurance?

8. What challenges are States likely to face in implementing the temporary reinsurance program?

9. How do other programs (e.g., Medicaid) use risk corridors to share profits and losses with health plans or other entities? How are the corridors defined and monitored under these programs? What mechanisms are used to collect and disburse payments?

10. Are there non-Federal instances in which reinsurance and/or risk corridors and/or risk adjustment were used together? What kinds of special considerations are important when implementing multiple risk selection mitigation strategies at once?

M. Comments Regarding Economic Analysis, Paperwork Reduction Act, and Regulatory Flexibility Act

Executive Order 12866 requires an assessment of the anticipated costs and benefits of a significant rulemaking action and the alternatives considered, using the guidance provided by the Office of Management and Budget. These costs and benefits are not limited to the Federal government, but pertain to the affected public as a whole. Under Executive Order 12866, a determination must be made whether implementation of the Exchange-related provisions in Title I of the Affordable Care Act will be economically significant. A rule that has an annual effect on the economy of \$100 million or more is considered economically significant.

In addition, the Regulatory Flexibility Act may require the preparation of an analysis of the economic impact on small entities of proposed rules and regulatory alternatives. An analysis under the Regulatory Flexibility Act must generally include, among other things, an estimate of the number of small entities subject to the regulations (for this purpose, plans, employers, and in some contexts small governmental entities), the expense of the reporting, recordkeeping, and other compliance requirements (including the expense of using professional expertise), and a description of any significant regulatory alternatives considered that would accomplish the stated objectives of the

statute and minimize the impact on small entities.

The Paperwork Reduction Act requires an estimate of how many "respondents" will be required to comply with any "collection of information" requirements contained in regulations and how much time and cost will be incurred as a result. A collection of information includes recordkeeping, reporting to governmental agencies, and third-party disclosures.

Furthermore, Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits and take certain other actions before issuing a final rule that includes any Federal mandate that may result in expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of \$135 million.

The Department is requesting comments that may contribute to the analyses that will be performed under these requirements, both generally and with respect to the following specific areas:

1. What policies, procedures, or practices of plans, employers and States may be impacted by the Exchange-related provisions in Title I of the Affordable Care Act?

a. What direct or indirect costs and benefits would result?

b. Which stakeholders will be affected by such benefits and costs?

c. Are these impacts likely to vary by insurance market, plan type, or geographic area?

2. Are there unique effects for small entities subject to the Exchange-related provisions in Title I of the Affordable Care Act?

3. Are there unique benefits and costs affecting consumers? How will these consumer benefits be affected by States' Exchange design and flexibilities and the magnitude and substance of provisions mandated by the Act? Please discuss tangible and intangible benefits.

4. Are there paperwork burdens related to the Exchange-related provisions in Title I of the Affordable Care Act, and, if so, what estimated hours and costs are associated with those additional burdens?

N. Comments Regarding Exchange Operations

The Exchange-related provisions in Title I of the Affordable Care Act may affect/will involve various stakeholders. HHS wants to ensure receipt of all

comments pertaining to the operations of the Exchanges.

1. What other considerations related to the operations of Exchanges should be addressed? If your questions related to the operations of Exchanges have not been asked, or you would like to add additional comments, you may do so here.

Signed at Washington, DC, this 27th day of July 2010.

Jay Angoff,

Director, Office of Consumer Information and Insurance Oversight, Department of Health and Human Services.

[FR Doc. 2010-18924 Filed 7-29-10; 11:15 am]

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FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 1

[WC Docket No. 07-245, GN Docket No. 09-51; FCC 10-84]

Implementation of Section 224 of the Act; A National Broadband Plan for Our Future

AGENCY: Federal Communications Commission.

ACTION: Proposed rule; correction.

SUMMARY: This document corrects a proposed rule published in the **Federal Register** on July 15, 2010, with respect to attachments to poles by any telecommunications carrier or cable operator providing telecommunications services. Specifically, this corrects how the maximum just and reasonable rate would be calculated under proposed rule § 1.1409(e)(2).

FOR FURTHER INFORMATION CONTACT: Marvin Sacks, 202-418-2017.

Correction

In proposed rule FR Doc. 2010-17048, beginning on page 41338 in the issue of July 15, 2010, make the following corrections in the **SUPPLEMENTARY INFORMATION** section. On page 41361 in the third column, under the proposed formula in § 1.1409(e)(2)(ii), delete the word "Maximum" before the word "Rate" and add the words "Maintenance and Administrative" before the words "Carrying Charge Rate," so the formula reads as follows:

Federal Communications Commission.

Bulah P. Wheeler,
Deputy Manager.

